Neighborhood Health Plan™

March 3, 2010

David Morales, Commissioner
Executive Office of Health and Human Services
Division of HealthCare Finance and Policy
Two Boylston Street
Boston, MA 02116

Dear Commissioner Morales:

On behalf of Neighborhood Health Plan, thank you for the opportunity to provide written testimony in accordance with the Division's request dated February 12, 2010 under Exhibit B as provided for in Massachusetts General Law, chapter 118G §6½. We share the concerns that many have expressed about the impact rising health care costs and higher premium trends are having on the residents of Massachusetts. Although Neighborhood Health Plan serves less than 1% of the commercially insured population in the Commonwealth, we welcome the opportunity to work with the Division on providing testimony to help inform a successful outcome to the hearing process.

Neighborhood Health Plan, also known as NHP, is a Massachusetts-based not-for-profit corporation with operational headquarters located at 253 Summer Street in Boston. NHP is fully licensed by the Massachusetts Division of Insurance as a Health Maintenance Organization. Central to the mission of NHP is to ensure that quality, affordable health care is being delivered to our members, and we strive to provide culturally competent health care and services to low income, underserved, diverse populations that cut across all race, ethnic, gender, age, orientation, and disability spectrums.

Our responses to the questions located in Exhibit B serve as NHP's written testimony. I, as a legally authorized and empowered representative of Neighborhood Health Plan, Inc., sign under the pains and penalties of perjury, that the testimony herein located at Exhibit B to the best of my knowledge is complete and accurate.

Sincerely,

David Segal
Chief Operating Officer

EXHIBIT B – Questions & Answers

Question 1: After reviewing the preliminary reports located at www.mass.gov/dhcfp/costtrends please provide commentary on any data or finding that differs from your organization's experience and the potential reasons therefore.

For context, Neighborhood Health Plan (NHP) serves MassHealth, Commonwealth Care, and Commercial members. Commercial membership represents approximately 15% of NHP's total membership. In addition, NHP's commercial membership represents less than 1% of the total Massachusetts commercial population. NHP includes all of the Massachusetts Community Health Centers (CHCs) as part of its provider network. With the predominance of government sponsors, and its close relationship with the CHCs, NHP is unique in the Massachusetts commercial market.

The DHCFP report references, "*the power health insurers have to influence service utilization and selection of care settings through targeted incentives for providers.*" While NHP would not differ with that statement, we would point out that targeted incentives require the agreement of and engagement with the associated providers. Given NHP's limited commercial market size, and therefore negotiating leverage in the commercial space, we have the challenge of creating incentives that will be consistent, rather than in conflict, with the targeted incentives of much larger health plans that generate greater revenue streams for any given provider.

Question 2: We found that much of the growth in medical spending over the time period studied is due to increases in prices rather than in utilization. From your plan's experience, how much of the increase in spending due to price is due to higher negotiated rates and how much is due to patients being seen at more expensive locations?

NHP's cost trend experience is similar to that in the DHCFP report. Our commercial product unit cost trend was mitigated slightly by employers choosing to purchase less rich benefit plans. On average, roughly 50-60% of the medical trends experienced were a result of unit cost, and 40-50% were due to utilization increases. Since medical expenses constitue 90% of health care premiums, NHP is engaging key provider stakeholders around the drivers of both quality and cost, considering both unit cost and utilization cost trends.

NHP has not performed explicit analyses for the purpose of differentiating the unit cost trend from a shift to more expensive locations. Based on our standard models for analyzing provider contract financial performance, we do not have any indicators demonstrating that we are experiencing that phenomenon. NHP has discovered that, in certain situations, there are an increasing number of community-based specialists who are contractually affiliated with large academic medical centers. As a result, while they may admit to smaller, more affordable hospitals, they are reimbursed at the higher rates associated with the physician organization of the larger academic medical centers. When these specialists are limited in supply, it has a marked impact on NHP's unit costs. We expect that, if left unabated, this will have a material impact on NHP's unit cost trend.

The availability of new diagnostic and treatment modalities is placing upward pressure on our trends. The availability and use of new diagnostic and treatment modalities has caused utilization to continue to trend upward in the 3-5% range each year. In addition, to the extent that academic medical centers expand into more suburban areas, unit cost trends will continue to be pushed upward.

The relative richness of benefit packages in Massachusetts also impacts the mix of services and locations where the services are provided, as members have little to no incentive to avoid unnecessary care or to seek high-quality yet less expensive alternatives. We would estimate that during the time period of the DHCFP analysis, the unit cost trend was between 5-7% and that the majority of this trend (4-5%) was due to hospital contract negotiations.

Over the last several years, MassHealth has not increased the rate of payment to NHP. To address this issue, NHP has worked with its hospital providers to hold down costs. NHP has been successful at holding hospital rate increases to near 0% for our Medicaid and Commonwealth Care members. Given the small size of NHP's commercial market share, we have seen increases in the 1.4% range.

Question 3: What factors do you consider when negotiating payment rates for inpatient care, facility charges for outpatient care, and physicians and other professionals? Please explain each factor and rank them in the order of impact.

First and foremost, NHP conducts its provider contracting activities with a focus on ensuring clinical quality, as reflected in its consistently high HEDIS® scores. In addition, NHP also considers the type of provider with whom we are negotiating. For instance, an integrated delivery system has more complexity than a stand-alone hospital.

Acute care hospital rates may be negotiated independently or as a component of an integrated health care delivery system or HCA. NHP's current hospital reimbursement methodologies include discounts from charge, per diem rate, case rate, or fee schedule payments.

Primary Care Providers (PCPs) and Specialty Care Providers are reimbursed on the basis of NHP's standard fee schedules for professional services. Providers may negotiate a multiple of the base rates, which may be driven by the availability of the provider specialty, geographic accessibility, or line of business based competitive drivers. Rates of reimbursement for professionals may also be negotiated as a component of a larger, integrated delivery system.

Skilled Nursing/Rehabilitation, Ambulatory Surgery Center, CHC, and Urgent Care Center rates of reimbursement are negotiated individually. However, the reimbursement methodology is standard across each provider type.

Ancillary Services reimbursement and reimbursement methodology are standard across ancillary types.

For any rate negotiation, the following factors are considered:

Acute Care Facility considerations (in order of impact on negotiated rates):

1. MassHealth reimbursement in the form of SPAD (Standard Payment Amount per Discharge) for inpatient services and PAPE (Payment Amount Per Episode)
2. Comparison to peers through plan level data as well as publically available cost and quality information
3. Types of services provided (i.e. specialty facility, academic medical center, general services, integrated delivery system)
4. Geographic location
5. Budgeted dollars available
6. Current or projected utilization by line of business

Physician/Professional reimbursement considerations:

1. CHC vs. non-CHC medical group practice
2. Medicaid and Medicare reimbursement comparison
3. Comparison to peers
4. Types of service provided (i.e. primary care, specialty, multi-specialty, integrated care system)
5. Geographic location
6. Budgeted dollars available
7. Current or projected utilization

Ancillary Provider reimbursement considerations:

1. 1-7 as noted above for physician/professional
2. Free standing services (i.e. urgent care, lab, radiology, etc.) – consider proximity to facility based outpatient services
3. Physician owned or independent entity

Question 4: Please identify any additional cost drivers that you believe should be explained in subsequent years and explain your reasoning.

Cost drivers may be attributed to unit cost changes through negotiation, standard fee schedule updates, or changes in utilization. Some utilization changes are directly explainable by the health care environment and lead to medical management strategies and activities. For example, in the second quarter of 2009, NHP experienced a surge in claims that were directly attributable to flu illness as compared to the same period in 2008. Although there is a straightforward cause and effect related to early H_1N_1 pandemic experience and medical expense for the health plan, this utilization would be used to inform quality and educational opportunities for members and the network providers in an effort to positively impact utilization and medical expense.

As mentioned in our response to Question 2 above, the impact of new technology on cost is noteworthy. Non-inpatient utilization trends will be most impacted by new technology, especially in radiology. NHP has implemented a radiology management program to mitigate this trend. We continue to track this trend and assess its impact on future utilization trend forecasts.

Member cost sharing changes have an immediate impact on utilization trend. The impact will vary depending on the type of service and the level of choice that the member has in seeking the service. For example, it has been NHP's experience that cost sharing on PCP visits and generic drugs will impact utilization much more than a co-payment on inpatient surgery. Of course, the impact of cost sharing has on NHP is highly dependent on our plan sponsors. MassHealth members do not have a cost sharing arrangement, and therefore we must rely heavily on member education and communication to foster using the right care at the right time. As mentioned earlier, NHP is actively engaging with key provider stakeholders so that we may create synergistic approaches to driving this behavior.

The majority of NHP's commercial member population is primarily located in the greater Boston area. Although NHP saw lower than average utilization trends, the geographic composition of our membership can often create additional cost pressures. For example, CHCs in the Boston area are important primary care partners. These sites provide high quality, culturally competent, and cost efficient primary care throughout the metropolitan area. However, due to historical relationships, the complex medical needs

of their patient panels, and geographic accessibility concerns these sites often refer to urban academic medical centers.

The changing demographics of the commercial population in Massachusetts has also had an impact on the rising trend in cost. The aging of the population impacts the cost trend of all commercial products. Since the introduction of the Commonwealth Choice product , the cost trend and medical loss ratios of the commercial small group product have risen. The vast array of choices offered to the commercial market appear to be negatively impacting the cost trend of the MCOs.

As the availability of primary care and particular provider specialties continues to decrease, providers and their negotiating entities will continue to hold leverage in demanding higher levels of reimbursement. This is most readily demonstrated in the geographic expansion of specialty hospitals and academic medical centers into community care facilities outside the greater Boston area.

Question 5: Please provide any additional comments or observations you believe will help to inform our hearing and our financial recommendations.

NHP shares many of the conclusions reached in the DHCFP report. We would like to offer some of our observations with respect to the potential effectiveness and likelihood of some of the proposed solutions. We believe that more investments in data transparency need to be made by all participants in the health care community. The relative price and quality of health insurers, as well as the relative cost and quality of physicians and institutions should proactively be made available to the public.

Payer and provider incentives do need to be more aligned. Developing mutually agreeable payment methodologies with a quality-driven foundation will help drive payers, providers, and consumers to more consistent and desirable behaviors. Greater integration of care would ultimately improve efficiency while providing high quality services.

Since our public policy goal is to slow the growth or even lower the cost of health care, the drive toward full global payment should be balanced against other ways to achieve the same objective, at least in the short term. For example, NHP contracts with all of the CHCs in Massachusetts. They are an integral part of our provider network and provide high-quality, affordable care to some of the Commonwealth's most needy citizens. We believe that they are able to play an active role in high-quality, affordable care. Patient Centered Medical Home models with shared savings, or even shared risks, may be more appropriate ways to reach our public policy goals in this instance.

Whether global payment or shared savings, it is important that we all understand the "starting point" for any of these payment arrangements. For example, as we have noted earlier, many community-based physician organizations are contractually affiliated with the physician organizations of large academic medical centers, and therefore reimbursed at the rates of those large physician organization. In addition, many academic medical centers are expanding their reach into the suburbs. To the extent that this trend goes unabated, we will begin our discussion about lowering costs starting from an inflated base. Creating select networks also holds promise for reducing medical cost trend. However, the employer community would have to actively support these select networks. The few experiments conducted with select networks in the past did not seem to bear fruit based on the minimal uptake by employer purchasers.